American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

July 21, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

RE: CMS Hospital Price Transparency Accuracy and Completeness Request for Information

Dear Administrator Oz:

On behalf of the American Hospital Association's (AHA's) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS') request for information (RFI) on the accuracy and completeness of hospitals' machine-readable files.

The AHA appreciates the agency's focus on improving price transparency. In addition to our online question submissions, we would like to share additional context and ideas on this topic. **Hospitals and health systems are dedicated to improving price transparency and look forward to working together with the Administration on this important goal.** The guiding principle of price transparency policies should be providing patients with clear and accurate information to help them prepare for care. An important secondary goal should be ensuring employers have the information they need as the primary purchasers of health care through employer-sponsored insurance.

We are concerned that the ongoing focus on the machine-readable files, rather than the consumer-friendly shoppable service information, diverts attention away from the price transparency efforts that are most meaningful to patients. **We encourage CMS to focus future efforts on the information that will best help patients understand and compare their expected costs prior to care.** The outsized focus on machine-readable file data can distract patients from the more intuitive tools that provide individualized,

and therefore most accurate, estimates based on their cost-sharing amounts, their progress toward meeting their deductible and other pertinent information such as patient demographics.

Moreover, individual policy improvements rather than a comprehensive review of the numerous and sometimes conflicting price transparency requirements at both the state and federal levels are not in the best interest of patients or employers. **We urge CMS to focus future efforts to reform price transparency on streamlining policies to remove complexity and administrative burden.** The current landscape of pricing information is challenging for patients and employers to navigate and use effectively, and it adds excessive costs, confusion and workforce burden to the health care system.[1,2,3] Addressing the hospital machine-readable files in isolation is misguided; CMS should coordinate and streamline any future changes across all hospital and insurer requirements to create a price transparency environment that is both usable and meaningful to patients and employers.

Please see below our specific comments and recommendations on the issues identified in the RFI.

ACCURACY AND COMPLETENESS OF THE MACHINE-READABLE FILE DATA

Determining the accuracy and completeness of machine-readable file data is inherently challenging given that exact rates do not exist in the way envisioned by this policy. This is because the data required in the machine-readable files, specifically the estimated allowed amount data, does not exist outside of what hospitals and insurers create to input into the files. In other words, because the files require hospitals to break down services in a manner that is not common for how rates are negotiated or stored in hospital or insurer internal systems, hospitals effectively must create new rates specific for this purpose. While they do their best to create negotiated rates that are as close as possible to how the final services may ultimately be paid, hospitals must make detailed assumptions about how to apply complex contracting terms and assess historic data to create a reasonable value for an expected allowed amount.

For example, to develop the negotiated rate for a colonoscopy, hospitals can use historic claims data to calculate the average price the insurer paid for the service previously, recognizing that variation exists due to differences in patient acuity and the care process (e.g., the amount of anesthesia required), as well as the potential for additional procedures that may be performed during the screening. These may include diagnostic interventions such as biopsies, polyp removal or lesion cauterization, each of

---

[1] https://www.aha.org/fact-sheets/2023-02-24-fact-sheet-hospital-price-transparency
[2] https://www.aha.org/system/files/media/file/2023/09/aha-comments-on-cms-outpatient-and-ambulatory-surgery-prospective-payment-system-proposed-rule-for-cy-2024-letter-9-8-23.pdf
[3] https://www.aha.org/system/files/media/file/2021/03/aha-comments-on-no-surprises-act-price-transparency-provisions-letter-3-16-21.pdf

which introduces additional clinical complexity, supply use, staff time and billing variation that can significantly affect the total allowed amount for the encounter. Hospitals may also apply additional expected contracting terms to that estimate (e.g., how modifiers or stop-loss provisions may impact the final payment amount) that introduce additional complexity to the calculation. This is even more complicated in instances where there is not sufficient, or any, historic data available on which to reasonably base the calculations. Ultimately, there is no tool or dataset that CMS could use to assess or verify these calculations, and **we continue to strongly support attestations of accuracy for purposes of CMS assessments.**

In addition, the machine-readable data is, at best, a historic representation of the likely payment amount for an item or service. It cannot be carried over to individual cases as the price for a specific patient's service will always require consideration of the unique factors of that case. For example, the negotiated rate for the colonoscopy discussed above likely would be lower than expected for a high acuity patient and higher than expected for a low acuity patient. Moreover, that amount does not reflect the patients' cost-sharing amount, but rather the total amount inclusive of both the insurer and patient responsibilities. Finally, even if the information was relevant to the patient, the machine-readable files are hard to navigate. For example, there likely would be multiple colonoscopy lines reflecting different types of procedures (e.g., preventive versus diagnostic) and patients would need to have high health care literacy to determine the correct line item. Moreover, none of this information accounts for how the cost for the patient would change if a preventive colonoscopy became a diagnostic colonoscopy mid-service, given how health insurance treats these instances differently.

Fortunately, there are tools that already exist to provide individualized estimates to patients as part of both the hospital and insurer shoppable service requirements. In addition, once the No Surprises Act is fully in effect, all patients will receive good faith estimates or advanced explanations of benefits prior to scheduled care, as the act requires. While these are by definition "estimates," they are much more likely to produce usable and reliable cost expectations than the machine-readable files because they are based on an individual's specific situation.

As an alternative, CMS could focus its efforts on ensuring that pre-service estimates are as accurate as possible. One way to do this would be to change benefit design requirements to reduce or eliminate cost-sharing that is calculated after the course of care is complete and instead rely solely on flat co-payments. That way, even if the total price varies as discussed above, the patient portion remains the same. Another alternative could be to remove providers from the cost-sharing collection process altogether and instead require insurers to be responsible for cost-sharing estimates and collections. This would incentivize more predictable and transparent benefit design as insurers would likely create more rational benefit packages if they were at risk for patient non-payment as providers are today.

ENFORCEMENT

Since the hospital price transparency requirements took effect in 2021, CMS has changed the requirements and guidance several times. While many of these changes have made expectations clearer and easier to comply with, their repeated implementation requires significant time and resources. Also, since 2021, CMS has steadily increased its enforcement efforts.[4] Between Jan. 7, 2021, and March 31, 2025, CMS engaged in over 6,000 audits and enforcement actions related to hospital price transparency compliance as part of over 3,000 unique cases. Of these more than 3,000 cases, almost 1,000 were found to comply at the time of the audit and another nearly 2,000 came into compliance following CMS action. Most of the roughly 300 remaining cases were opened in 2025 and the hospitals in question are now actively working to come into compliance. It is because of hospitals' efforts that CMS has only issued 27 civil monetary penalties, rather than a lack of CMS' active auditing or enforcement.

As a result of a steep learning curve, many of the initial issues CMS identified required weeks, or sometimes months, for hospitals to resolve. The issues identified now are typically minor, and AHA has heard from hospitals that cases are often opened and closed within hours. We understand that the relationship between CMS and hospitals throughout this process has been positive and collaborative and we appreciate CMS' willingness to work with hospitals to achieve compliance.

Given the prolific auditing and enforcement already occurring, additional enforcement of the hospital price transparency requirements is not necessary. However, there are steps that CMS could take that would help streamline the auditing and compliance process. To begin, we recommend that CMS notify hospitals following a positive audit to let them know that they have been found to be in compliance with the requirements. It appears that CMS tracks this based on the publicly available enforcement data, but hospitals are not currently receiving this information directly from CMS. In addition, we have heard from many hospitals that more clarity in CMS' initial warning notices would be helpful. In many instances, delays in responding to compliance concerns are due to confusion around what issue CMS is identifying. If CMS could provide more detail about what specific issues they found during their audits, hospitals would be able to more promptly address them.

Finally, we encourage CMS to direct additional auditing and enforcement resources to the Transparency in Coverage requirements. As discussed previously, the insurer data holds great potential to advance CMS' price transparency objectives and allow for better streamlining but these benefits will not be realized until the data is more usable and reliable.

[4] https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/hospital-price-transparency-enforcement-activities-and-outcomes

Thank you for your consideration, and we look forward to working with the Administration to improve price transparency for patients. Please contact me if you have questions or feel free to have a member of your team contact Ariel Levin, AHA's director of coverage policy, at 202-626-2335 or alevin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President, Public Policy Analysis and Development